DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10519

Registration District No. 1 2 5 — Primary Registration District No. 3009 — Registrar's No. 118

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: S.E.Mo. Hospital (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)

In this community 2 mo

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cape Girardeau

(c) City or town Rural (If outside city or town limits, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Josephine Bodenschatz

3. (b) If veteran, name war ____ 3. (c) Social Security No. ____

4. Sex F | 5. Color or race W. | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife Albert F Bodenschatz | 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Dec (Month) 22 (Day) 1887 (Year)

8. AGE: Years 52 | Months 2 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace St Louis Mo (City, town, or county) (State or foreign country)

10. Usual occupation Housework

11. Industry or business ____

MOTHER FATHER

12. Name Wm Krenger

13. Birthplace Germany (City, town, or country) (State or foreign country)

14. Maiden name Emilia Wehmeyer

15. Birthplace New Wells Mo (City, town, or country) (State or foreign country)

16. (a) Informant's own signature Emilia Wehmeyer

(b) Address New Wells Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 23 1940 (Month) (Day) (Year)

(c) Place: burial or cremation New Wells

18. (a) Signature of funeral director McCombs Funeral Co

(b) Address Jackson Mo

19. (a) 3-26-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20th year 1940 hour 11:30 minute a. M.

21. I hereby certify that I attended the deceased from March 19th, 1940, to March 20th, 1940, that I last saw her alive on March 20th, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cardiac decompensation	1 week
Due to Bilateral hydrothorax	2 mos.
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) ____

(b) Date of occurrence ____

(c) Where did injury occur? ____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)

While at work? ____ (e) Means of injury ____

23. Signature G B Schuck (M. D.)

Address Cape Girardeau Mo Date signed 3/28/40

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REV. 5-1-39 1 X19511

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 105-19

Registration District No. 125 — Primary Registration District No. 3009 — Registrar's No. 118

SUPPLEMENTARY

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write "RURAL")
(d) Street No. (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Josephine Bodenschatz
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex F | 5. Color or race W | 6. (a) Single, ~~widowed, married, divorced~~ Widowed

6. (b) Name of husband or wife
6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 52 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 3-20-40 (Date received local registrar) (b) J. M. Thompson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 20
year 1940 hour minute M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. B. Schultz (M. D. or other)
Address Cape Girardeau Mo. Date signed

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

S-10579 - 1940